

111TH CONGRESS
1ST SESSION

S. 648

To amend title XVIII of the Social Security Act to establish a prospective payment system instead of the reasonable cost-based reimbursement method for Medicare-covered services provided by Federally qualified health centers and to expand the scope of such covered services to account for expansions in the scope of services provided by Federally qualified health centers since the inclusion of such services for coverage under the Medicare program.

IN THE SENATE OF THE UNITED STATES

MARCH 19, 2009

Mr. BINGAMAN (for himself, Ms. SNOWE, and Mr. SANDERS) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to establish a prospective payment system instead of the reasonable cost-based reimbursement method for Medicare-covered services provided by Federally qualified health centers and to expand the scope of such covered services to account for expansions in the scope of services provided by Federally qualified health centers since the inclusion of such services for coverage under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Medicare Access to
3 Community Health Centers (MATCH) Act of 2009”.

4 **SEC. 2. FINDINGS.**

5 Congress finds that:

6 (1) NATIONAL IMPORTANCE.—Community
7 health centers serve as the medical home and family
8 physician to over 16,000,000 people nationally. Pa-
9 tients of community health centers represent 1 in 7
10 low-income persons, 1 in 8 uninsured Americans, 1
11 in 9 Medicaid beneficiaries, 1 in 10 minorities, and
12 1 in 10 rural residents.

13 (2) HEALTH CARE SAFETY NET.—Because Fed-
14 erally qualified health centers (FQHCs) are gen-
15 erally located in medically underserved areas, the pa-
16 tients of Federally qualified health centers are dis-
17 proportionately low income, uninsured or publicly in-
18 sured, and minorities, and they frequently have
19 poorer health and more complicated, costly medical
20 needs than patients nationally. As a chief component
21 of the health care safety net, Federally qualified
22 health centers are required by regulation to serve all
23 patients, regardless of insurance status or ability to
24 pay.

25 (3) MEDICARE BENEFICIARIES.—Medicare
26 beneficiaries are typically less healthy and, therefore,

1 costlier to treat than other patients of Federally
 2 qualified health centers. Medicare beneficiaries tend
 3 to have more complex health care needs as—

4 (A) more than half of Medicare patients
 5 have at least 2 chronic conditions;

6 (B) 45 percent take 5 or more medica-
 7 tions; and

8 (C) over half of Medicare beneficiaries
 9 have more than 1 prescribing physician.

10 (4) NEED TO IMPROVE FQHC PAYMENT.—While
 11 the Centers for Medicare & Medicaid Services have
 12 nearly 15 years’ worth of cost report data from Fed-
 13 erally qualified health centers, which would equip the
 14 agency to develop a new Medicare reimbursement
 15 system, the agency has failed to update and improve
 16 the Medicare FQHC payment system.

17 **SEC. 3. EXPANSION OF MEDICARE-COVERED PRIMARY AND**
 18 **PREVENTIVE SERVICES AT FEDERALLY**
 19 **QUALIFIED HEALTH CENTERS.**

20 (a) IN GENERAL.—Section 1861(aa)(3) of the Social
 21 Security Act (42 U.S.C. 1395x(aa)(3)) is amended to read
 22 as follows:

23 “(3) The term ‘Federally qualified health center serv-
 24 ices’ means—

1 “(A) services of the type described in subpara-
 2 graphs (A) through (C) of paragraph (1), and such
 3 other ambulatory services furnished by a Federally
 4 qualified health center for which payment may oth-
 5 erwise be made under this title if such services were
 6 furnished by a health care provider or health care
 7 professional other than a Federally qualified health
 8 center; and

9 “(B) preventive primary health services that a
 10 center is required to provide under section 330 of
 11 the Public Health Service Act,

12 when furnished to an individual as a patient of a Federally
 13 qualified health center and such services when provided
 14 by a health care provider or health care professional em-
 15 ployed by or under contract with a Federally qualified
 16 health center and for this purpose, any reference to a rural
 17 health clinic or a physician described in paragraph (2)(B)
 18 is deemed a reference to a Federally qualified health cen-
 19 ter or a physician at the center, respectively. Services de-
 20 scribed in the previous sentence shall be treated as billable
 21 visits for purposes of payment to the Federally qualified
 22 health center.”.

23 (b) CONFORMING AMENDMENT TO PERMIT PAY-
 24 MENT FOR HOSPITAL-BASED SERVICES.—Section
 25 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is

1 amended by inserting “Federally qualified health center
2 services,” after “qualified psychologist services,”.

3 (c) EFFECTIVE DATES.—The amendments made by
4 subsections (a) and (b) shall apply to services furnished
5 on or after January 1, 2010.

6 **SEC. 4. ESTABLISHMENT OF A MEDICARE PROSPECTIVE**
7 **PAYMENT SYSTEM FOR FEDERALLY QUALI-**
8 **FIED HEALTH CENTER SERVICES.**

9 (a) IN GENERAL.—Paragraph (3) section 1833(a) of
10 the Social Security Act (42 U.S.C. 1395l(a)) is amended
11 to read as follows:

12 “(3)(A) in the case of services described in sec-
13 tion 1832(a)(2)(D)(i) the costs which are reasonable
14 and related to the furnishing of such services or
15 which are based on such other tests of reasonable-
16 ness as the Secretary may prescribe in regulations
17 including those authorized under section
18 1861(v)(1)(A), less the amount a provider may
19 charge as described in clause (ii) of section
20 1866(a)(2)(A) but in no case may the payment for
21 such services (other than for items and services de-
22 scribed in section 1861(s)(10)(A)) exceed 80 percent
23 of such costs; and

1 “(B) in the case of services described in section
2 1832(a)(2)(D)(ii) furnished by a Federally qualified
3 health center—

4 “(i) subject to clauses (iii) and (iv), for
5 services furnished on and after January 1,
6 2010, during the center’s fiscal year that ends
7 in 2010, an amount (calculated on a per visit
8 basis) that is equal to 100 percent of the aver-
9 age of the costs of the center of furnishing such
10 services during such center’s fiscal years ending
11 during 2008 and 2009 which are reasonable
12 and related to the cost of furnishing such serv-
13 ices, or which are based on such other tests of
14 reasonableness as the Secretary prescribes in
15 regulations including those authorized under
16 section 1861(v)(1)(A) (except that in calcu-
17 lating such cost in a center’s fiscal years ending
18 during 2008 and 2009 and applying the aver-
19 age of such cost for a center’s fiscal year end-
20 ing during fiscal year 2010, the Secretary shall
21 not apply a per visit payment limit or produc-
22 tivity screen), less the amount a provider may
23 charge as described in clause (ii) of section
24 1866(a)(2)(A), but in no case may the payment
25 for such services (other than for items or serv-

ices described in section 1861(s)(10)(A)) exceed
80 percent of such average of such costs;

“(ii) subject to clauses (iii) and (iv), for
services furnished during the center’s fiscal
year ending during 2011 or a succeeding fiscal
year, an amount (calculated on a per visit basis
and without the application of a per visit limit
or productivity screen) that is equal to the
amount determined under this subparagraph
for the center’s preceding fiscal year (without
regard to any copayment)—

“(I) increased for a center’s fiscal
year ending during 2011 by the percentage
increase in the MEI (as defined in section
1842(i)(3)) applicable to primary care
services (as defined in section 1842(i)(4))
for 2011 and increased for a center’s fiscal
year ending during 2012 or any succeeding
fiscal year by the percentage increase for
such year of a market basket of Federally
qualified health center costs as developed
and promulgated through regulations by
the Secretary; and

“(II) adjusted to take into account
any increase or decrease in the scope of

1 services, including a change in the type, in-
 2 tensity, duration, or amount of services,
 3 furnished by the center during the center's
 4 fiscal year,

5 less the amount a provider may charge as de-
 6 scribed in clause (ii) of section 1866(a)(2)(A),
 7 but in no case may the payment for such serv-
 8 ices (other than for items or services described
 9 in section 1861(s)(10)(A)) exceed 80 percent of
 10 the amount determined under this clause (with-
 11 out regard to any copayment);

12 “(iii) subject to clause (iv), in the case of
 13 an entity that first qualifies as a Federally
 14 qualified health center in a center's fiscal year
 15 ending after 2009—

16 “(I) for the first such center's fiscal
 17 year, an amount (calculated on a per visit
 18 basis and without the application of a per
 19 visit payment limit or productivity screen)
 20 that is equal to 100 percent of the costs of
 21 furnishing such services during such cen-
 22 ter's fiscal year based on the per visit pay-
 23 ment rates established under clause (i) or
 24 (ii) for a comparable period for other such
 25 centers located in the same or adjacent

1 areas with a similar caseload or, in the ab-
2 sence of such a center, in accordance with
3 the regulations and methodology referred
4 to in clause (i) or based on such other
5 tests of reasonableness (without the appli-
6 cation of a per visit payment limit or pro-
7 ductivity screen) as the Secretary may
8 specify, less the amount a provider may
9 charge as described in clause (ii) of section
10 1866 (a)(2)(A), but in no case may the
11 payment for such services (other than for
12 items and services described in section
13 1861(s)(10)(A)) exceed 80 percent of such
14 costs; and

15 “(II) for each succeeding center’s fis-
16 cal year, the amount calculated in accord-
17 ance with clause (ii); and

18 “(iv) with respect to Federally qualified
19 health center services that are furnished to an
20 individual enrolled with a MA plan under part
21 C pursuant to a written agreement described in
22 section 1853(a)(4) (or, in the case of a MA pri-
23 vate fee for service plan, without such written
24 agreement) the amount (if any) by which—

1 “(I) the amount of payment that
 2 would have otherwise been provided under
 3 clause (i), (ii), or (iii) (calculated as if ‘100
 4 percent’ were substituted for ‘80 percent’
 5 in such clauses) for such services if the in-
 6 dividual had not been enrolled; exceeds

7 “(II) the amount of the payments re-
 8 ceived under such written agreement (or,
 9 in the case of MA private fee for service
 10 plans, without such written agreement) for
 11 such services (not including any financial
 12 incentives provided for in such agreement
 13 such as risk pool payments, bonuses, or
 14 withholds) less the amount the Federally
 15 qualified health center may charge as de-
 16 scribed in section 1857(e)(3)(B);”.

17 (b) EFFECTIVE DATE.—The amendment made by
 18 subsection (a) shall apply to services furnished on or after
 19 January 1, 2010.

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